

## London ambulance chaos due to risky computer system

The head of the London Ambulance Service, Jim Harris, resigned last week after the publication of a highly critical report into the chaotic attempt at computerising the service. The report, the result of an independent inquiry, accused management of putting in place a risky, imperfect system that did not have the confidence of ambulance crews or staff at central ambulance control.

Virginia Bottomley, the secretary of state for health, admitted that she was concerned at the findings of the report. She has asked South West Thames Regional Health Authority to report to her within a month on ways of strengthening the chain of management responsibility between it and the service.

David Blunkett, the opposition health spokesman, called for the resignation of Tom Sackville, the junior health minister with responsibility for the London Ambulance Service. Only days before the system collapsed Mr Sackville had told MPs that he was satisfied with it and that the problems were related to the behavioural problems of staff rather than technical.

Despite press and union reports that the introduction of the computer led to 20 deaths the report says that no one died as a direct result of ambulances arriving late during the chaos that followed computerisation. But the report severely criticises the management of the London Ambulance Service for its "misguided" decision to implement the computer aided dispatch system in one phase on 26 October.

The system was overambitious, and it was developed and implemented, the report says, against an impossible timetable. The management of the service "ignored or chose not to accept advice provided to it from many sources" on the tightness of the timetable.

Yet the team recommends that the service should press on with introducing a computer aided dispatch system. Last week the service said that introducing a tried and tested system would take up to four years.

On 26 and 27 October last year, because the system could not correctly identify which vehicles were available and where they were, it incorrectly sent multiple vehicles to the same incident or failed to send the closest vehicle.

The time it took for the service to answer 999 calls rose to an average of 10 minutes and was sometimes as long as 15 minutes. When ambulances did not arrive calls from the public asking what had happened further lengthened the time taken to answer.



ULRIKE PREUSS

*Ambulance crews had no confidence in the new computer system*

Each time an ambulance was allocated the system anticipated a series of events: the ambulance station would acknowledge the call, the crew would press a button in the correct ambulance, and the ambulance would then move a certain distance within two minutes. But if this did not happen—and it did not—the system generated messages that required action at the central control office. On the two days after implementation so many of these messages were generated that staff found it difficult to identify which calls had already been dealt with.

### Neither the system nor its users were ready

It is clear, the report says, that neither the system itself nor its users were ready for implementation. The software had not been fully tested. Neither ambulance crews nor staff at the central ambulance control were fully trained.

The service had taken a high risk by awarding the contract for the system to a small software house with no experience of similar systems. This company, Systems Options, had submitted the lowest tender, of only £35 000. The system eventually cost £1.5 million.

The system did not fail in a technical sense on the first two days, the report says, although the "fatal flaws" in it cumulatively led to all the symptoms of failure. As a result, by 28 October staff at central ambulance control had reverted to the semimanual method of operation that they had used before the new system was introduced. But, at 2 am on 4 November, the system slowed significantly and then "locked up" altogether. Staff then reverted to a system based solely on paper with voice and telephone communications to mobilise ambulances. The inquiry team concluded that the system crashed because of a minor programming error that caused it gradually to use up its memory.

The report says that there was a culture within the London Ambulance Service of "fear of failure," with management continually under pressure to succeed. Management clearly misjudged the industrial relations climate "so that staff were alienated to the changes rather than brought on board." Management, says the report, should now give "serious thought to how to demonstrate its commitment to, and appreciation of, its most valuable asset—namely, its staff."—SHARON KINGMAN, freelance journalist, London

## Headlines

**US drops health benefit tax:** The White House health care task force, chaired by Mrs Hillary Clinton, has abandoned the idea of taxing health benefits that workers receive from employers. The original proposal was to help finance reform of national health care. Higher tobacco taxes are being considered.

**Medicines Information Bill:** The Medicines Information Bill has been amended to make available only summarised information rather than the full data behind drug licensing decisions by the Medicines Control Agency in Britain. The bill now awaits a third reading in the House of Commons.

**WHO chief faces fraud inquiry:** Fraud detection experts from Britain's National Audit Office have been called in to examine staff and payment records at the World Health Organisation as part of an investigation into the management and re-election campaign of its Japanese director general, Dr Hiroshi Nakajima.

**British companies dominate private hospitals:** British companies now own or manage 40% of the country's independent hospitals, compared with 3% in 1980. The number of beds in independent acute psychiatry and substance misuse units have increased to over 2700—a 45% increase since 1987. The figures are given in a new report from the Independent Healthcare Association.

**No civil rights for Britain's disabled people:** The Civil Rights (Disabled Persons) Bill failed to proceed into its committee stage last week. After a five hour debate the bill was blocked by the government whips. The bill's sponsor, Alf Morris, will present it again on 26 March.

**Two new chief executives:** Tim Matthews, chief executive of St Thomas's Hospital, will be chief executive of the combined Guy's and St Thomas's Hospital. The director of the King's Fund Centre, Barbara Stocking, has been appointed chief executive of Oxford Regional Health Authority.

**Abortion pill may be allowed in US:** The president of Roussel-Uclaf, which manufactures mifepristone, has discussed with the American food and drug commissioner how the abortion pill could be marketed in the US by another company or research institution. The company has been reluctant to seek approval because of political pressure.

## Hospital league tables expected soon

The British public will soon be able to see how hospitals are performing as the Department of Health begins to publish league tables. Speaking at a conference organised by the National Association of Health Authorities and Trusts last week, the NHS's chief executive, Sir Duncan Nichol, said that the NHS Management Executive and the Audit Commission were working together on the publication of "accessible, comparative information on performance." The league tables are likely to be produced before the end of 1994.

Sir Duncan wants to accelerate the range of information made available with the aim of raising the public's ability "to judge, influence, and choose" health services. He said that waiting lists were "a crude and one dimensional" way of monitoring a hospital's performance.

Initially key indicators will be developed for measuring targets set out in the patient's charter—waiting times for admission, ambulance response times, waiting times in accident and emergency departments, waiting times in outpatient departments, the proportion of operations cancelled, and the proportion of procedures performed as day case surgery.

Sir Duncan told reporters that no decision had been made about the format of the tables or whether they would be published on a regional basis, but he promised that they would be user friendly and state clearly a hospital's performance. He expects regional targets to be set in April on the maximum time a patient should wait before seeing a specialist for the first time. Performances in relation to this target will probably be included in the league tables from 1995. A Department of Health spokesperson emphasised

later that there was no question of publishing details of individual specialties or of death rates at individual hospitals.

The Labour party's health spokesman, Mr David Blunkett, gave a cautious welcome to the announcement, saying, "We support patient choice and improved performance but these must be built on local cooperation rather than competition."

The BMA hoped that any information published would not be misleading. It pointed out that variations in performance could be affected by local differences. These could be social, geographical, or related to patients' access to other parts of the health service. The association also said that league tables could raise patients' hopes if they were given information about outstanding hospitals to which they could not be referred.

—LINDA BEECHAM, *BMJ*

## India to check sale of places in medical colleges

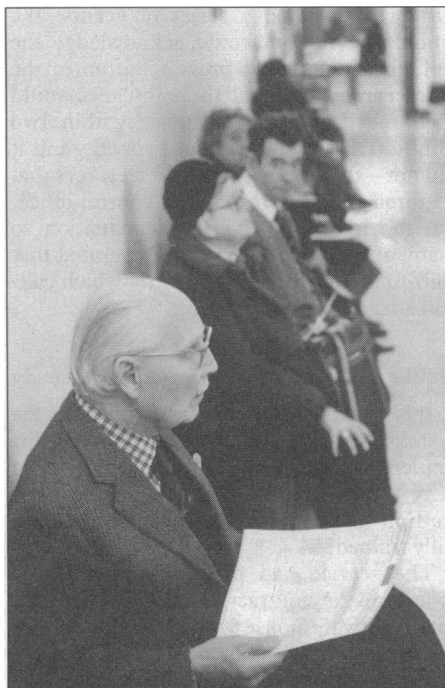
The Indian Supreme Court has ordered an end to students buying their way into private medical colleges regardless of merit. The landmark judgment will stop arbitrary admissions through donations of large sums of money but will allow private colleges to charge higher fees than those charged by government institutions. Merit will now be the sole criterion for all entrants.

The system of students joining undergraduate medical colleges by paying donations, also known as "capitation fees," had led to widespread concern in sections of the medical community and among health authorities (*BMJ* 1992;305:979). Students entering medical courses by paying capitation fees are usually those who have failed to secure seats through merit—determined by their grades in higher secondary school exams or by national entrance tests.

Entry on the basis of donations is practised in medicine and engineering—India's most popular subjects for professional study. Private medical and engineering colleges have sprung up across India over the past two decades in response to a growing demand for these courses. The number of medical colleges has risen from 25 in 1950 to 150 last year. About one third of these are privately funded.

Although private colleges do admit meritorious students nominated by the government, the colleges' authorities also have a quota of "management seats," which are usually sold to the highest bidding students, resulting in a blatant commercialisation of education. Many private colleges in four Indian states (Karnataka, Tamil Nadu, Andhra Pradesh, and Maharashtra) charge capitation fees ranging from 200 000 rupees (£5000) to 600 000 rupees (£15 000) from such students entering the five year course in medicine.

Medical organisations in India have condemned this system and demanded a curb on new medical colleges. India already has



Long waits in outpatients could ruin a hospital's position in the league tables

JOHN COLE/IMPACT

100 000 practising doctors, and 14 000 students graduate annually from the 120 medical colleges recognised by the Medical Council of India. "There is no shortage of doctors, but the standard of training imparted today is far from ideal," said Dr Praful Dalal, president of the Association of Indian Physicians.

India's various state governments have allowed new medical colleges to take in students without insisting on basic prerequisites like equipment, laboratories, or qualified faculty members, according to the health ministry in New Delhi. The medical council, which periodically inspects medical colleges, has still not recognised 26 colleges because they lack the required facilities. "Some new medical colleges charging capitation fees are poorly equipped and provide scanty facilities for training students," said Dr Kirpal Chugh, former president of the Association of Indian Physicians and a member of the Medical Council of India. "At best such institutions can be termed teaching shops."

In the past the central government and various state governments have contemplated legislation to ban capitation fees, but they were stalled, reportedly, by private institutions lobbying in favour of the existing practice.

The new judgment from the Supreme Court, delivered on 4 February, will put an end to arbitrary admissions by abolishing the quotas of management seats. All private institutions will have to abide by a new scheme outlined by the court, which will come into effect from the next academic year (1993-4). Under the new scheme half of all places in private colleges are to be filled by students nominated by the government, who will pay the regular fees charged by government colleges. The other half will be called "payment seats" and will be filled by students willing to pay higher fees. But allocation of students for the payment seats will also be done on the basis of merit.

The judgment thus acknowledges the need for private institutions to be financially viable, by allowing them to charge higher fees. Colleges cannot, however, fix these fees arbitrarily. The amount will be determined by a committee drawn from autonomous bodies such as the University Grants Commission and the Medical Council of India. — GURU NANDAN, science writer, New Delhi

## Italy retreats from community care for mentally ill

The Italian government has changed its mind on mental illness, reversing the hotly debated law 180, which closed mental hospitals and released patients into the community. According to a new bill, doctors should have the right to transfer mentally ill patients to hospital against their will, while local health authorities must provide new day centres, clinics, and community housing.

Under the old law Italian doctors were not



*Italians are tolerant of the mentally ill in the community*

allowed to send mentally ill people to hospital without their consent. "This new bill will stop once and for all the tragic cases of people who are incapable of recognising the severity of their illness," said a spokesman for the health ministry.

Professor Pier Luigi Scapicchio, president of the national association of psychiatrists, has welcomed the proposal but denies that the bill reverses the famous law 180. "It was a great law," he says, "but in handing responsibility to the patient rather than the doctor it went a little bit over the top." In the 1970s Franco Basaglia, a professor first at the mental hospital in Gorizia and then in Trieste, taught that mental illness is merely a condition imposed by society.

Law 180, passed in 1978, encapsulated many of his ideas, especially that of freeing mentally ill patients from institutions and reintegrating them with their families and into the community. Most of Italy's mental hospitals, housing 60 000 patients, were closed.

But while mental hospitals were closed, insufficient funds were provided for services in the community. All too often patients were simply put out on the streets or sent back to reluctant families. According to one psychiatrist, "This law has cost us 10 years of people committing suicide, and there are still thousands of people dying of hunger and cold in hospitals and clinics."

The new bill includes sanctions for local health authorities that fail to provide adequate facilities for mentally ill people. "Local authorities have four months to implement the new legislation," says Professor Scapicchio, "otherwise the health ministry will take over responsibility for mentally ill patients."

The professor says that other European countries should learn from the Italian experience. "It simply is not possible for a civilised country to keep up lunatic asylums in the year 2000," he says. "But do not make the same mistakes we have. German, French, and British authorities should close down their asylums, slowly replacing them with more modern facilities."

In the absence of adequate replacements for the old asylums some 40 Italian mental hospitals have remained open. The most notorious is in Siracusa in Sicily, where fewer than 10 nurses care for over 300 patients—visitors have compared this hospital to a concentration camp.

"Law 180 has failed because the political will never existed to implement it," argues Professor Franco Rotelli, the successor to the late Professor Basaglia at Trieste's psychiatric hospital. Law 180 has not entirely failed as a social experiment. Italians have proved tolerant of reintegrating mentally ill patients into the community.

More controversial is an article in the new bill that permits doctors to call in the police if the patient refuses to enter psychiatric hospital. Professor Tommaso Losavio, president of the Movement of Democratic Psychiatrists, warns that the amendment hands too much authority to doctors.

The bill will now be discussed by health and social affairs committees and seems destined for amendment before parliament votes on the new law. The reform has already won the backing of Italy's current prime minister, Giuliano Amato, who once described supporters of Basaglia's theory on insanity as "a species close to extinction but not worth saving." —CHRIS ENDEAN, Rome correspondent, *European*

CHRIS DAVIES/NETWORK

## Regions to be slimmed and reviewed

The 14 regional health authorities in England must be slimmed down and looked at rigorously to see how they function and interrelate with the work of the NHS Management Executive, the secretary of state for health, Virginia Bottomley, said last week.

For several months the secretary of state for health has been expected to make a radical announcement about the future of regional health authorities, perhaps abolishing them. But when Mrs Bottomley addressed a conference organised by the National Association of Health Authorities and Trusts she told her audience that the authorities would continue to be responsible for delivering NHS objectives, including those for public health.

Regions will continue to manage purchasers, family health services authorities, and general practice fundholders. But regional health authorities were too large, said Mrs Bottomley, and she wanted their staff reduced from an average of 560 to a maximum of 200. The deputy chairman of the management executive, Mr Alan Langlands, will head a functions and manpower review of the regions, aided by Ms Kate Jenkins, a member of the NHS Policy Board. Mrs Bottomley has asked them to report on their progress by the summer.

At present six NHS outposts monitor NHS trusts, and the minister promised an announcement shortly on whether they would each be strengthened to cope with the increasing number of trusts or whether new ones would be set up.

Mrs Bottomley said that she had earmarked £4m to stimulate progress on purchasing in 1993-4. Purchasers had five basic tasks: assessing needs, setting standards, targeting resources, demanding value for money, and monitoring quality.

The Labour party's health spokesman, Mr David Blunkett, said that the decision to keep the regional authorities and the outposts while ordering a further review is a sign of befuddled thinking and unfought battles in the cabinet. "The growing confusion in the relationship between the Department of Health, the regions, the NHS Management Executive, and its outposts is set to continue," he said. — LINDA BEECHAM, *BMJ*

## Law Commission suggests help for mentally incapable

A new legal framework for taking decisions on behalf of people in Britain who are unable to manage their own affairs was suggested by the Law Commission in a report last week. The proposals would plug a gap in the law which hampers relatives and carers of mentally handicapped adults, people with serious head injuries, and elderly people with senile dementia. Under existing law no one, not even the court, has the power to make day to

day decisions about care and welfare for mentally incapable people and there is no power to appoint a decision maker, except in financial affairs.

The commission, the official law reform body for England and Wales, suggests that a new judicial body should be set up with power to make orders about care and welfare or to appoint a "personal manager" to take decisions. This would take over powers now exercised by the Court of Protection to supervise mentally incapacitated people's property and finances. The new body would have power to make orders mirroring those that can be made for children under the Children Act, deciding whom a mentally incapable person should live with and who else should have contact and dealing with any other specific issue arising.

Other changes in the law would allow carers, without a court order, to do anything reasonable in caring for an incapacitated person as long as they acted in his or her best interests. People would be able to make a power of attorney delegating decisions about personal care to a friend or relative, to take effect if they later become incapable of looking after themselves. At present these cover only financial decisions and decisions concerning property. Banks, building societies, and insurance companies would be able, at their discretion, to release funds to carers lodging a "certificate of incapacity," without a court order.

The law would incorporate safeguards to protect incapacitated and vulnerable people from exploitation, abuse, and neglect. A future report will deal with medical decisions. — CLARE DYER, legal correspondent, *BMJ*

*Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction* is available from HMSO, price £8.50.

## Treat urgent cases, says NHS executive

Evidence from doctors that patients in Britain needing urgent investigations and treatment are being told that they must wait until the next financial year has resulted in the chief executive of the NHS issuing a statement saying that this is unacceptable. Some hospitals have imposed quotas for the number of urgent cases that consultants can treat, and one general surgeon was told to reduce the number of patients with cancer treated each week from seven to four.

In his letter to regional and district general managers and chief executives of trust hospitals Sir Duncan Nichol says that patients should not be offered greatly different standards of care depending on the time in the financial year. Although it is essential to adhere to financial targets, he points out that there must still be a consistent and proper approach to patients who need urgent investigation or treatment. He wants more explicit standards for treating urgent cases and says that these standards should be developed with clinicians and incorporated into contracts. Doctors' representatives have started discussions with the NHS Management Executive.

Mr John Chawner, the chairman of the Central Consultants and Specialists Committee, said that the chief executive's letter was the direct result of pressure that doctors had put on ministers. The BMA had received anecdotal evidence of difficulties and his committee, he said, had backed this up with a survey conducted in January and February. The results were published last week. A questionnaire was sent to nearly 1000 consultant members of the BMA in short stay



No one has the power to make day to day decisions for mentally incapable people

JOHN TWINNING

specialties. There was a 42% response rate, and just over half of the respondents said that specific measures had been introduced in their units to restrict activity for financial reasons. There was little difference between trust hospitals and directly managed units. About a third of the respondents said that the contract with the main purchaser had been completed and that no further funds would be available; 85% of these had responded by restricting activities.

The most common form of restrictions were bed or ward closures and cancellation of operating sessions. Thirty one per cent of the units reporting restrictions said that they were taking non-emergency patients only from general practice fundholders or other purchasers with funds. Another 20% restricted admissions to those with long waiting times, and 17% had banned non-emergency admissions. Three per cent reported restrictions on emergency admissions or closure of the casualty department.

Mr Chawner said that it was worrying that 16% of consultants reported cases being vetoed by managers—implying that surgeons could no longer exercise clinical judgment. The main problem, he said, was that contracts were not providing enough money for units to work properly. The BMA and his committee had been pointing out since 1986 that the short stay sector was underfunded. —LINDA BEECHAM, *BMJ*

## Growth hormone victims seek compensation

The government is under growing pressure to set up a compensation scheme for people treated with human growth hormone between 1959 and 1985, eight of whom have died of Creutzfeld-Jakob disease aged between 20 and 34. An early day motion signed by 120 MPs calls on the government to establish a fund for recipients of the hormone like that set up for haemophilic and other people infected with HIV through NHS treatment.

The hormone, extracted from the pituitary glands of cadavers, was given to children of short stature but was withdrawn after reports of deaths from Creutzfeld-Jakob disease in the United States. In 1985 it was replaced by genetically engineered hormone.

The incubation period of the virus that causes the degenerative brain disease may be as long as 35 years. There is no test to detect the virus before symptoms appear. Once the disease manifests itself dementia is rapid and death usually occurs within 12 months.

The latest victim, 31 year old Patrick Baldwin, a former engineer in the Royal Navy, died just before Christmas, and a ninth recipient of the hormone is suspected to have the disease.

Doctors have no idea how many of the 1900 others who were treated with the hormone will succumb. It was only in 1991, after the sixth death, that the Department of Health agreed to a programme to trace, notify, and counsel all recipients of the hormone.

Solicitors coordinating claims on behalf of



Patrick Baldwin who acquired Creutzfeld-Jakob disease from human growth hormone

the families of victims have written to the Department of Health's lawyers asking for disclosure of key documents about the production and supply of growth hormone. The lawyers are preparing to seek a court order for disclosure if the department refuses.

The hormone used in the NHS was never licensed under the Medicines Act. It was produced by the Medical Research Council in laboratories at Cambridge University and St Bartholomew's Hospital Medical School before production was transferred to the government laboratory at Porton Down in Wiltshire in 1980. All those who have developed the disease were given the hormone before 1980.

The Department of Health applied for a product licence in 1977, but the application was turned down because the department's medicines inspectorate advised the licensing authority that the laboratory facilities fell short of the department's standards for the manufacture of products from living tissue.

Pituitaries were collected from cadavers by mortuary technicians, who were paid 10p a gland. Former technicians interviewed for Channel 4's *Check Out '92* programme last year said that some of their colleagues screened out pituitaries from cadavers with infections or dementia but others forwarded pituitaries indiscriminately.

The government denies that it could have known of the risk of transmission of the virus, although evidence of this was mounting through the 1970s. A paper in *Science* in 1968 first documented the transmission of Creutzfeld-Jakob disease experimentally. Between 1974 and 1982, cases of transmission after corneal transplantation, the use of depth electrodes, and possible contamination by neurosurgical instruments were reported.

One stumbling block to the setting up of a compensation fund is the question of whether to compensate those who have not developed the disease and may never do so. The lawyers are seeking compensation for them as well, arguing that they are economically disadvantaged in seeking jobs, will have to pay

more for insurance and mortgages, and suffer stress from the constant fear that they might develop the disease. Tom Fry, director of the self help and campaigning Child Growth Foundation, said: "We know of two men who have decided not to marry because of the possibility that they may leave a young family bereft." —CLARE DYER, legal correspondent, *BMJ*

## France half hearted in tobacco battle

In the four months since France adopted legislation restricting smoking in public places no one has been fined for smoking cigarettes illegally. People are still smoking in public places, and the price of cigarettes has increased less than smokers feared.

Most restaurants have no-smoking signs, but the small cafés—daily stopovers for innumerable French men and women—vaguely relegate non-smokers to one side of the counter or the other. Some owners have defiantly posted a sign saying "non-smokers accepted."

The Paris Transport Authority (RATP) does not vigorously enforce the smoking ban in the corridors of the metro, but it reports that the number of cigarette ends on the floor has decreased. None of the 80000 or so members of the national hotel syndicate has reported any incidents since the decree.

One of the strongest antismoking measures to be effected this year was a 30% increase in the price of cigarettes. A 15% tax increase has gone into effect, but some manufacturers decided to absorb part of it. Another 15% increase is scheduled for next month. Even so, French cigarettes will still be much cheaper than cigarettes in most countries in the European Community. Cigarette advertising has been banned, causing the press to complain of losing up to 30% of their advertising revenue. —ALEXANDER DOROZYNSKI, medical journalist, Paris

## Model for GMC?

Britain's 2500 osteopaths are now in sight of the statutory professional recognition that they have pursued for 60 years. The Osteopaths Bill is making progress through parliament with the government's blessing and should reach the statute book this summer.

The bill paves the way for the creation of a statutory governing body, the General Osteopathic Council, modelled on the General Medical Council (GMC). Only those practitioners who meet the required standards of education and competence and are registered with the General Osteopathic Council will be permitted to call themselves osteopaths. Existing osteopaths who have been practising safely for five years will be able to register.

The medical profession's antipathy was finally extinguished in 1988 when the Prince of Wales persuaded the presidents of the royal colleges to agree that osteopathy was truly complementary to conventional medicine and that the way was clear for the statutory regulation of osteopaths. The resulting bill is the seventh attempt and is being piloted in the Commons by a Conservative MP, Malcolm Moss, and in the Lords by the medical peer Lord Walton of Detchant.

In most years that would be the end of the story so far as doctors are concerned. The Osteopaths Bill has special relevance, however, since it creates a precedent for future statutory regulation, not least the forthcoming amendment of the Medical Act applying to doctors. The government has had a guiding hand in drafting the Osteopaths Bill, and the junior health minister, Tom Sackville, holds it up as a model for others to follow. He said that it embodies the most up to date thinking on professional self regulation.

The important innovations are in the clauses dealing with fitness to practise and setting new standards in disciplinary procedures that doctors may find they have to follow. The provision for compulsory refresher training as a condition of continuing registration is the least of these. The Osteopaths Bill, for instance, avoids the term "serious professional misconduct," which has been at the root of so much trouble recently for the GMC. Instead, the comparable hazard for osteopaths will be "unacceptable professional conduct," which many think is sufficiently broad to cover allegations of poor performance by doctors also.

Nevertheless, the new bill erects the additional hurdle of "incompetent practice" as an explicit reason for disciplinary investigation. This is currently unique among statutory schemes regulating health care professions and is analogous to what the GMC proposes to introduce in a more cumbersome way as "serious deficiency of performance." An osteopath found guilty of incompetent practice could be removed from the register. The maximum sanction proposed so far for doctors is indefinite suspension.

Up to date thinking also favours the possible instant suspension of a practi-

tioner before any charges are investigated. In the case of osteopaths either the professional conduct committee or the health committee may order suspension pending investigation if it is satisfied that this is necessary to protect the public. The power of suspension could be used, for example, to defer a professional investigation until any criminal proceedings had been dealt with. Or it might be used to stop an osteopath practising who posed an obvious risk to patients through ill health. Such powers are

also unique among the health professions.

Amendments during the bill's committee stage have had the effect of lowering thresholds for disciplinary action against an osteopath and tend to accord with what critics of the GMC would like to see enacted for doctors. Whether this is the shape of things to come for the medical profession remains to be seen. Amending legislation could come as early as next session. The GMC still prefers its own terminology. — JOHN WARDEN, parliamentary correspondent, *BMJ*

## The Week

### Restoring professionalism to general practice

The next generation of general practitioners could be providing a range of core services to their patients with family health services authorities paying for extra services that they want to purchase. In exchange for such practice based agreements—with reduced managerial control—doctors might be willing to commit themselves to a system of accreditation.

These suggestions come in a wide ranging discussion document *General Practice: Which Way Forward?* which General Medical Services Committee chairman, Ian Bogle, has written and sent to his committee. He pulls no punches and clearly sets out the risks in initiating a new contractual system. The power of FHSAs might increase; a more precise definition of general medical services could lead to more explicit obligations; there would be an effective end to the expectation of "a job for life"; a new contractual system would meet head on the profession's traditional aversion to change; and general practitioners might lose their power base to other professionals. But Ian Bogle believes that the benefits might outweigh the risks. These include restoring morale and professionalism; making the payment system more sensitive to work done; stopping the inexorable expansion of general medical services, enabling new work to be identified and funded accordingly; simplifying the payment system; allowing local variations to be negotiated; and enabling work to be delegated safely.

Why propose such an upheaval only three years after the 1990 contract? Because, argues Bogle, that contract finally brought to an end the era of the family doctor charter. It introduced greatly increased management control over general practitioners and coincided with the introduction of the first cash limits in general practice. It created anomalies and inequities such as deprivation payments, health promotion arrange-

ments, and capitation based payments.

Dr Bogle believes that low morale and low job satisfaction among general practitioners have never been so prevalent: they are a recurring theme at GMSC meetings. The key issues he sees underlying dissatisfaction are an excessive workload, some of which includes inappropriate tasks, and the conflict between the expectations of the independent contractor and those of NHS managers. He suggests that new contractual arrangements could both restore professionalism and ensure the standards and accountability expected by the public and the government.

Dr Bogle wants to scotch the idea that there is no such thing as a bad doctor, and he is bold enough to say, "A few doctors are careless, a few are incompetent, and a few are even dangerous." He believes that for too long the profession has failed to admit the problem of bad practice. "We must no longer allow ourselves to be seen as supporting the insupportable, accepting the unacceptable, or defending the indefensible."

Although not many doctors are in a rush to introduce a system of quality control—a discussion document on the subject was pilloried at a recent GMSC meeting—a majority of the respondents to the GMSC's survey *Your Choices for the Future* were prepared to consider a system of professional reaccreditation. But they also wanted it to be managed by the profession and not controlled by those who see it as an integral part of the internal NHS market.

The GMSC has a good track record of producing thought provoking papers. This one should certainly provoke debate at local medical committees and this year's LMC conference. Ian Bogle's hope must be that morale among general practitioners is not so low that they see only the risks and not the opportunities.

HART